INDIVIDUAL SUPPORT, CRISIS PREVENTION AND INTERVENTION PLAN
Short Version

PART I – FACE Sheet

Demographics

Name: Click here to enter name

Region: Click here to enter region

Date: Click here to enter a date

ID #: Click here to enter #

D.O.B.: Click here to enter a date

Telephone #: Click here to enter #

Address: Click here to enter address

Living Situation (check appropriate box):

☐ lives with parents/guardian
☐ lives with spouse/partner
☐ lives alone
☐ other (please specify) Click here to specify

Describe: Click here to describe

	Diagnosis		Insurance
Axis I	Click here to enter information	**Medicaid #**	Click here to enter #
Axis II	Click here to enter information	**Medicare #**	Click here to enter #
Axis III	Click here to enter information	**Private Ins. #**	Click here to enter #
Axis IV	Click here to enter information	**Other**	Click here to enter
Axis V	Click here to enter information	**Other**	Click here to enter

Current Medication (both prescription and over the counter)

As of : Click here to enter a date

medication Click here to enter	**dose** Click here to enter	**frequency** Click here to enter
medication Click here to enter	**dose** Click here to enter	**frequency** Click here to enter
medication Click here to enter	**dose** Click here to enter	**frequency** Click here to enter
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medication Click here to enter	**dose** Click here to enter	**frequency** Click here to enter

Medical/Dental Conditions

Click here to enter information about medical and/or dental conditions

Communication Style - Primary Language (note receptive and expressive language)

Click here to primary language information

Strengths/Skills/Interests

Click here to enter skills & interest information

Circle of Support/Providers

Type	Agency	Name	Address	Phone Number
Guardian	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Family/friend contact	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Residential Program	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Work Program	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Case manager	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Individual Clinician	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Primary Physician	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Psychiatrist	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Therapist	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
Neurologist	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #
MH Team	Click here to enter agency	Click here to enter name	Click here to enter address	Click here to enter phone #

PART II – General Guidelines

Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; skills, interests, does best when given "space," ways to develop rapport, etc.)

*These are things that we see on an ordinary day***:**

Click here to enter general patterns of behavior information

Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):

Click here to enter stress increase information

Describe alternatives that have been effective in keeping the individual out of crisis.: What can be tried in the current setting

Click here to enter historically effective alternatives

PART III - Disposition Recommendations: When the person needs to leave home for help

Specify what options have been most successful in the past; whether the individual has been to respite and did well there, which hospital is the hospital of choice if necessary, etc.

Click here to enter successful options information

PART IV - Back-Up Protocol

Outline specific protocols under which <u>the START team, mental health crisis team or other first responders will be accessed</u>. Who should be called in case of an emergency? How can they be reached? What will happen when family member/care giver contacts them? BE AS SPECIFIC AS POSSIBLE include contact names, phone numbers, hours of operation, etc. Protocol should be initiated to prevent crisis at *earliest signs of difficulty*.

What may happen	What to do	Who to call	Phone number
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #
Click here to describe	Click here to describe	enter name	enter phone #

PART V - Signatures/Approvals

NAME: Click here to enter name

CIRCLE OF SUPPORT SIGNATURES		
	Signature	***date***
Individual (OPTIONAL)	Click here to enter name	Click here to enter a date
Family member/friend	Click here to enter name	Click here to enter a date
DMR/DMHAS Case Manager	Click here to enter name	Click here to enter a date
Psychologist	Click here to enter name	Click here to enter a date
Psychiatrist	Click here to enter name	Click here to enter a date
Primary medical provider	Click here to enter name	Click here to enter a date
Day/Voc Program rep.	Click here to enter name	Click here to enter a date
Advocate	Click here to enter name	Click here to enter a date
Neurologist	Click here to enter name	Click here to enter a date
Respite program rep.	Click here to enter name	Click here to enter a date
Mental Health Crisis Team representative	Click here to enter name	Click here to enter a date
Other	Click here to enter name	Click here to enter a date

ADMINISTRATIVE APPROVAL		
	Initials	***date***
DMR Administrator	Click here to enter initials	Click here to enter a date
Mental Health Crisis team administrator	Click here to enter initials	Click here to enter a date